

Improvements suggested by Enthoven and Maynard

Darrin Baines MSc, PhD

In our series on the history of prescribing policy, Dr Darrin Baines traces how successive governments have attempted to curb drug costs. Here, he describes the proposals suggested by Alain Enthoven and Alan Maynard in the 1980s.

KEY EVENTS

- **1985** Miners' strike ends – On 3 March 1985 the National Union of Miners voted to return to work, giving the Thatcher administration a major political victory
- **1985** Alain Enthoven's monograph published – Professor Enthoven suggests plans that lead to the introduction of the NHS internal market as part of the 1991 reforms
- **1985** Professor Alan Maynard suggests proposals for budget-holding that eventually lead to the introduction of the GP fundholding scheme

The ending of the UK miners' strike in March 1985 was deemed a major political victory for Margaret Thatcher and the Conservative Party, which significantly weakened the trade union movement. On the back of this victory, the Thatcher administration seemed unstoppable in its fight against powerful vested interests, which were deemed to harm innovation and economic prosperity.

With an unemployment rate of over 3 million, the mid-1980s was a period of economic hardship and lower Exchequer revenues. In response, the operation of public services and their related expenditures came under close scrutiny. For instance, the Thatcher administration explored further how new management and economic techniques could be used within the NHS, particularly to improve efficiency and control costs.

Enthoven's report

In June 1985, the Nuffield Provincial Hospitals Trust published Alain Enthoven's reflections on the management of the NHS.¹ In the 1960s, Enthoven had served as US Assistant Secretary of Defense, with responsibilities including programme budgeting, systems analysis and economic evaluation. Working as an economist in the 1980s, Professor Enthoven was invited to write

about the NHS 'as if a man from Mars'. From this perspective, he looked at 'incentives to efficiency' in health services management. *The Economist* magazine of 22 June 1985 reported that the professor's main proposal for 'an experimental internal market in the NHS could be very important'.

Highly in favour of demonstration projects for his ideas, Professor Enthoven suggested district-level purchasing of healthcare services based upon local patient needs and funded through weighted capitation budgets. However, he warned that 'to bring about efficiency-improving changes, it is generally necessary to get people to do things differently from the way they have in the past. This can create dislocations, winners and losers and opposition'.

Against the background of the Griffiths report on NHS management, Enthoven concluded that, 'in competition, doctors impose on themselves controls they would never dream of accepting if the government tried to impose them'. Therefore, 'clinical freedom is giving way to effective control of quality and cost-effectiveness'.

With the road to reform clearly laid out in Professor Enthoven's monograph, Margaret Thatcher's government had to choose whether to face the dislocations

and battles such radical changes would stimulate. As the subsequent 1991 reforms demonstrated, the administrations choose the route of managerial and economic rationalism, despite the potential for major political and professional opposition.²

Maynard's practice budgets

Four months after the publication of Enthoven's report, the Office of Health Economics held a meeting on NHS general practice, which was attended by the Chief Medical Officer, Dr Donald Acheson. At the meeting, Professor Alan Maynard, Director of the Centre for Health Economics at the University of York, gave a presentation on performance incentives in general practice.³

Professor Maynard stated that, in general practice, the 'occasional attempts to control expenditure are usually weak. Apart from moral-suasion ("be reasonable chaps!") about expenditure generally, the usual specific controls are applied to the drug budget.' However, he argued that prescribing policy was fraught with difficulties because, on the one hand, the government promoted the prosperity of the pharmaceutical industry with the PPRS and, on the other, tried to reduce drug costs to the NHS.

In all this, the 'tax payer gets an uncertain deal' because medicines budgets are open-ended and benefits to patients are uncertain. Like many other parts of government, much money is spent but 'little effort is made to ensure that the expenditure gives value for resources'.

As specific solutions to the sustained problem of growing prescribing costs in general practice, Professor Maynard suggested the use of a cost-effectiveness hurdle for new products and pharmaceutical budgets for controlling the growth in public expenditure on drugs. As part of the latter option, he suggested that family doctors could be allocated practice drug budgets and, if they spent more than their allotted sums, their personal incomes could be reduced. However, if they spent less, their remuneration could be improved.

Despite the benefits that such a scheme could offer, Professor Maynard cautioned that pharmaceutical budgeting would need 'careful specification and evaluation in experiments'. Indeed, he cynically asked: 'why not design and carry out an experiment and "confuse" policy discussion with facts rather than often self-interested rhetoric?'

As a system that rewarded under-spending and penalised overspends,

Maynard's budget scheme was very similar to the Floating Sixpence introduced in 1913.⁴ As history demonstrated, this early attempt to use incentives and penalties to control drug costs led to under-prescribing and widespread rationing. Consequently, pharmaceutical budgets had not been used by any government in the UK since 1920 – a situation that was about to radically change due to the Conservative government's adoption of Professor Maynard's idea.

References

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Darrin Baines is associate professor, Faculty of Medicine and Health Sciences, University of Nottingham

In the next instalment in this series, Dr Baines will examine proposals for greater pharmacist involvement in pharmaceutical care.